



DAVID M. MCGAFFIN
D.D.S., P.A.

Patient Information:

Patient's Name: _____
Last First Middle Preference
Birthdate: _____ Male / Female: _____ Marital Status: _____
Social Security #: _____ Driver's License #: _____ State: _____
Address: _____
Street Apt. # City State Zip
Cell: _____ Home: _____ Work: _____ ext _____
Email Address: _____ Employer: _____
Spouse's Name: _____ Birthdate: _____ Social Security #: _____
Spouse's Employer: _____ Spouse's Work Ph: _____
Is a member of your family a patient here: _____ Name: _____
How did you hear about us? : _____
Person to contact in case of an emergency: _____ Phone: _____

Responsible Party Information:

Self: _____ Other: _____
Last First Middle
If "Other," please complete: Relationship to Patient: _____
Birthdate: _____ Social Security #: _____ Driver's License# : _____
Address: _____
Street Apt. # City State Zip
Home Ph: _____ Work Ph: _____ ext _____

Insurance Information:

Name of insured: _____ Relationship to Patient: _____
Birthdate: _____ Social Security #: _____ Employer: _____
Insurance Co: _____ Group #: _____ Phone: _____

Patient's Signature: _____ Date: _____

Parent/Guardian signature if patient is a minor: _____